

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

30821

1. PLACE OF DEATH

County Clay

Registration District No. 201

Township Liberty

Primary Registration District No. 3012

City Liberty (No.)

File No.

Registered No. 79

St. Ward)

2. FULL NAME

Mildred A. Monroe

(a) Residence, No. St., Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. / How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Dan Monroe

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-11-1872

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
59 6 4

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife 54 B

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. 122B

10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kentucky

13. NAME Greengrass Byrd

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ky.

17. INFORMANT (ADDRESS) Otis Byrd Liberty Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty Mo DATE 9-17, 1931

19. UNDERTAKER (ADDRESS) Marvin Heasel Liberty Mo.

20. FILED 9-17, 1931 W. H. Wattlepodson Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9-15, 1931

22. I HEREBY CERTIFY, That I attended deceased from Sept 11, 1931, to Sept 15, 1931. I last saw her alive on Sept 15, 1931. Death is said to have occurred on the date stated above, at 6 P m.

The principal cause of death and related causes of importance were as follows:

Obstruction of bowel
Block of bowel caught in adhesion from fibroid of uterus

Other contributory causes of importance:

Name of operation..... Date of.....
What test confirmed diagnosis?..... Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide?..... Date of injury....., 19..... Where did injury occur?..... (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury..... Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?..... If so, specify..... (Signed) W. H. Wattlepodson, M. D. (Address) Liberty Mo

OCT 28 1931

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Clay Registration District No. 201 File No. _____
 Township Liberty Primary Registration District No. 3012 Registered No. 79
 City Liberty (No. _____) St. _____ Ward _____

2. FULL NAME Mildred A. Monroe

(a) Residence, No. _____ St. _____ Ward _____
 (Usual place of abode) (if nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED M
(write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) _____

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work _____
 (b) General nature of industry, business, or establishment in which employed (or employer) _____
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) _____

14.

INFORMANT _____
 (Address) _____

15.

FILED 11/10/01 W. H. Goodson
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9/15 1931

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Obstruction of bowel
with bowel caught
in adhesions from
typhoid & uterine
 (duration) _____ yrs. mos. ds.
 CONTRIBUTORY Not Malignant
 (SECONDARY) (duration) _____ yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____

IF NOT AT PLACE OF BIRTH _____

DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) _____, M. D.
 , 19____ (Address) _____

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

N. B.—Every item of information ab-
 applied. AGE should be stated EXACTLY. PHYSICIANS should state
 CAUSE OF DEATH in plain terms, so that properly classified. Exact statement of OCCUPATION is very important.
 REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-30821